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	155760	A. BUILDING 00 B. WING	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	1332 WATERFORD CIRCLE GOSHEN, IN46526

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 9, 10, 11, 12 and 13, 2011 Facility number: 011150 Provider number: 155760 AIM number: 200831020 Survey team: Mavis Stob, RN TC Carol Miller, RN Honey Kuhn, RN Census bed type: SNF/NF: 17 SNF: 36 Total: 53 Census payor type: Medicare: 13 Medicaid: 17 Other: 23 Total: 53 Sample: 14 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.The Maples at Waterford Crossing Health Campus desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 12, 2011The Maples at Waterford Crossing Health Campus respectfully requests this Plan of Correction be submitted as desk review for compliance for the deficiencies cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 5/19/11 by Jennie Bartelt, RN.			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to assure a care plan in regard to pacemaker use was revised for 1 of 1 resident with a pacemaker in a sample of 14. (Resident #36) Findings include: The clinical record of Resident #36 was	F0279	It is the expectation of this facility to use the results of the assessment, to develop, review, and revise the resident's comprehensive plan of care.What corrective action will be done by the facility?Resident #36 Pace maker care plan was revised. Physician order was received to notifiy physician if heart rate drops below 60 or greater than	06/12/2011

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	reviewed on 5/10/11 at 3:00 P.M., and indicated diagnoses which included but were not limited to atrial fibrillation (AF), coronary artery disease (CAD) pacemaker insertion and was receiving Hospice care. There was no care plan in the clinical record for the pacemaker. During interview on 5/11/11 at 3:15 P.M., the DNS (Director of Nursing Services) indicated the family, hospice and the physician indicated pacemaker checks were no longer necessary and the care plan had been discontinued, however the pacemaker was still in place. Documentation on the daily vital signs sheet for the months of April and May 2011, indicated the resident's pulse rate ranged from 68 to 118 beats per minute. There was no care plan to indicate what pulse rate parameters would warrant physician notification. 3.1-35(a)		120. Care plan was iniciated to include notification orders. How will the facility identify other residents having the potential to be effected by the same practice and what corrective action will be taken?An audit of resident charts with identified pacemakers has been completed. No other resident's were found to be effected by this alleged deficiency.What measures will be put into place to ensure this practice does not recur?The facility reviewed its policy and found it to be sufficient. The Director of Health Services, or designee, will audit all new admissions and those residents found to be with pacemakers will have a plan of care written and implemented to address the pacemaker at time of admission.How will corrective action be monitored to ensure the deficit practice does not recur and what QA will be put into place?Residents admitted with pacemakers will have their medical chart audited within the first seventy-two (72) hours of admission, and quarterly, by the Director of Health Services, or designee, to assure that compliance with care plan requirements are met. To begin immediately and will be ongoing.The DHS will report monthly to the Quality Assurance Committee on outcomes of the audits for the next 6 months, and thereafter as determined by the	

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			Quality Assurance Committee. The DHS is responsible for substantial compliance. By what date the systemic changes will be completed: June 12, 2011	
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on interviews and record review, the facility failed to follow the physician's order in regard to administration of medication to assure medications were not given twice. This deficiency resulted in a significant medication error that affected 1 of 14 residents whose medications were reviewed in a sample of 14 (Resident # 29). Findings include: The undated most current policy for Medication Administration Times Procedural Guidelines was received on 5/5/11 at 10:45 a.m., from the Administrator.	F0333	It is the expectation of this facility to ensure that residents are free of any significant medication errors.What corrective action will be accomplished for those residents found to have been effected by the deficient practice:Following medication error for resident #29 the physician and family were notified. Physician order was received to monitor blood pressure and pulse every hour and notify physician for blood pressure reading of anything less than 90 systolic, and 60 diastolic. No ill effects were noted during the assessment, and blood pressure remained above 90 systolic and 60 diastolic.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:An audit of resident medication records found no defcit practices, no other residents were identified.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Facility reviewed its policy and found it to be sufficient. Licensed staff were	06/12/2011

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	Review of the policy indicated, "...Purpose: to provide guidelines for the times of medication administration. Procedure: 1. ...Trilogy Health Services honors the resident's right to self determine their schedule and care choices and to maintain an environment and routine similar to their pattern prior to residing at the campus. 2. Unless a specific time is designated by the attending physician medications shall be administered at the following times: a. QD - (every day) after the resident awakens in the morning (morning is designated as times between 4 AM and 10 AM) b. BID - (two times a day) in the morning and at bedtime... 3. the nurse administering the		reeducated on medication administration and prevention of medication errors. Licensed staff will complete a competency for medication administration. See exhibit A and B attachedHow the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:Director of Health Services or designee will conduct random weekly medication administration observations. See exhibit C. Audits will be submitted to the Auality Assurance committee monthky for 6 months.By what date the systemic changes will be completed: June 12, 2011	

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	medications shall record the time the mediation was administered along with his/her initials. a. The nurse shall note the time of the previous dose prior to administering the same medication to ensure it is not provided too close together...." The clinical record of Resident #29 was reviewed on 5/12/11 at 11:00 A.M. The record indicated Resident #29's diagnoses included, but were not limited to, dementia, a history of bleeding ulcers, hypertension, and depression. A Medication Error Circumstance, Assessment and Intervention form, dated 5/4/11 at 0900 (9:00 A.M.), indicated the resident's "...medication given by two diff (different)			

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	nurses @ (at) two diff times...." The resident's physician was notified and an order was received to monitor the resident's blood pressures. The Nurse's Notes, dated 5/12/11, with a late entry for 5/4/11 at 1000 (10:00 A.M.), indicated "Med (medication) error reported by day shift nurse, stated am (a.m.) meds (levaquin 500 mg, (milligrams) nnusol supp (suppository) secrtal 200 mg, norvasc 5 mg, catapres 0.1 mg, cymbalta 30 mg, aricept 10 mg, Losartan potassium 25 mg, Zanaflex 2 mg) were given twice, night shift nurse had given @ 0600 (6:00 a.m.), and day shift nurse checked all meds but looked at wrong date on MAR (Medication Administration Record)...."			

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	The Physician's Order Sheet, dated 5/2011, indicated the following: administer Losartan Potassium 250 mg one tablet once a day (for high blood pressure), Zanaflex 2 mg one half tablet once a day (muscle spasms), Norvasc 5 mg one tablet once a day (high blood pressure), Catapres 0.1 mg one tablet once a day (high blood pressure), Cymbalta 30 mg one capsule once a day (depression), Aricept 10 mg one tablet once a day (dementia), Levaquin 500 mg one tablet once a day (urinary tract infection), and Anusol suppository one twice a day (inflammation). On 5/13/11 at 10:00 A.M., during interview with the Unit Manager (UM) #9 in regard to			

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	the medication errors that had occurred on 5/4/11 at 0900 (9:00 A.M.), UM #9 indicated morning medications had been given and signed out by the third shift Nurse LPN #15. The UM indicated when the first shift Nurse LPN #12 saw that the resident was awake, LPN #12 checked Resident # 29's morning medications against the Medication Administration Record (MAR). The Unit Manager #9 indicated LPN # 12 had not checked to see if the resident's medications were already signed out as given, and UM #9 indicated LPN #12 found the medication errors after she gave the resident the medications and LPN #12 had come back to the MAR to sign she had given the medications. Unit Manager #9 indicated she is unsure why Resident #29 had			

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	not stopped and told Nurse #12 that she had already had her morning medications. UM #9 indicated the resident had a decline in her condition and was not as alert as she had been previously. UM #9 indicated after the medication errors had occurred, the Physician had been contacted and Resident #29's blood pressures were monitored and remained above 90 systolic and 60 diastolic. The UM #9 indicated LPN #12 should have checked the resident's MAR to see if the medications had already been given. On 5/13/11 at 10:15 A.M., the Director of Nursing Services (DNS)was interviewed in regard to the medication error on 5/4/11, and indicated she had counseled LPN #12 after			

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	the medication errors had occurred. On 5/13/11 at 11:15 A.M., Employee File for LPN #12 was reviewed and indicated a date of hire 9/9/10, and LPN #12 had been oriented on medication administration. On 5/13/11 at 11:45 A.M., LPN #12 was interviewed in regard to Resident #29's medications error and indicated she had checked the medications names with the MAR but must had looked at the wrong date and she had not seen that the medications were already signed out as given. 3.1-48(c)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, observation and interviews, the facility failed to assure records were accurate in regard to the correct Cardiopulmonary Resuscitation (CPR) code status documented on the Resident First Care Assignment form. (Resident #27) The facility also failed to ensure documentation of assessment related to the use of catheters was complete. (Residents #52 and 36) This deficiency affected 1 of 14 residents whose CPR code status was reviewed and 2 of 2 residents with indwelling catheters in a sample of 14.	F0514	It is the expectation of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.The clinical record must contain sufficient information to identify the resdient; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.What corrective action will be accomplished for those residents found to have been effected by the deficient practice: Resident#27 CPR code was verified with the resident and physician. Resident First Care guides and resident medical record was updated to reflect full code CPR status. Resident #52 had catheter assessment	06/12/2011

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	Findings include: 1. Review of the clinical record of Resident #27 on 5/10/11 at 10:00 A.M., indicated Resident #27 was admitted on 10/27/10, with diagnosis which included, but were not limited to, dementia and depression. Prior to the initial resident tour on 5/9/11 at 11:40 A.M., Unit Manager #9 provided a Resident First assignment form, updated on 5/9/11 at 11:00 A.M., that indicated Resident #27's code status as full CPR (cardiopulmonary resuscitation). The CPR consent form signed by the resident's son, who was the resident's Power of Attorney, and dated 7/21/2010, indicated no CPR was to be performed. The Physician's Order Sheet dated 5/2011, indicated the Advanced Directives were documented that		completed and indwelling foley catheter use was found to be necessary due to the presence of a stage four (4) pressure ulcer located on the coccyx to prevent contamination and impede healing to the wound. Care plan was updated. Resident #36 had catheter assessment completed and assessment was reviewed with resident and physician. Physician dictated a diagnosis of "Neurogenic Bladder". Care plan updated.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: An audit of resident Advance Directives and Resident First Care guides was completed and no defcit practices were found, no other residents were identified. An audit of residents with foley catheters was completed and no deficit practices were found.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The facility reviewed its policy regarding assessments and found it to be sufficient. Residents admitted will have their medical chart audited within the first seventy-two (72) hours of admission, and quarterly, by the Director of Health Services, or designee, to assure that compliance in regards to catheter usage is met. Advance Directives will be reviewed upon admission,	

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	Resident #27's code status was no CPR. On 5/12/11 at 10:00 A.M., the Director of Nursing Service (DNS) was interviewed in regard to the resident's code status and the DNS indicated Resident #27 was to be a no CPR code status. The DNS indicated that CNA #11 who was responsible for typing the Resident First assignment form was unsure why the code status was typed incorrectly. 2. On 5/9/10 at 11:A.M., during the entrance tour, accompanied by the Unit Manager #9, Resident #52 was observed to have an indwelling catheter in place. The unit director of the 300 hall indicated the catheter was required to prevent contamination to the resident's sacral ulcer. The clinical record of Resident #52 was reviewed on 5/10/11 at 10:15 A.M., and indicated an admission date of 9/27/10, and diagnoses		confirmed with resident and physician, and updates to the Resident First Care guides within the first seventy-two (72) hours of admission. To begin immediately and will be ongoing.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The DHS will report monthly to the Quality Assurance Committee on outcomes of the reviews for the next 6 months, and thereafter as determined by the Quality Assurance Committee. The DHS is responsible for substantial complianceBy what date the systemic changes will be completed: June 12, 2011	

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	which included but were not limited to malnutrition and sacral ulcer. The resident had been attending the wound clinic and a wound vac had been in place on admission. The resident no longer attended the wound clinic and the wound vac had been discontinued. There was no catheter assessment form in the clinical record and during interview on 5/10/11 at 2:00 P.M., the unit director indicated she was unsure why the catheter assessment form had not been completed. 3. On 5/9/11 at 11:10 A.M., during the entrance tour, accompanied by the Unit Manager #9, Resident #36 was observed to have a catheter in place. At this time the Unit Manager indicated the resident was receiving hospice care and the catheter was required due to urinary retention. The clinical record of Resident #36 was reviewed on 5/10/11 at 3:00			

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	P.M., and indicated diagnoses which included but were not limited to atrial fibrillation and history of CVA (cerebral vascular accident-stroke). A significant change MDS (minimum data set) assessment, dated 3/2/11, indicated an indwelling catheter was in place. The catheter assessment form, dated 5/4/11, indicated the reason for the catheter was retention. There was an area on the form which indicated supporting information for the catheter insertion should be assured. Review of the record did not indicate supporting documentation. During interview on 5/11/11 at 3:15 P.M., the DNS indicated the resident was to have a consultation with a urologist. 3.1-50(a)(1) 3.1-50(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155760	A. BUILDING 00 B. WING	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	1332 WATERFORD CIRCLE GOSHEN, IN46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE